DEPARTMENT OF THE AIR FORCE

HEADQUARTERS UNITED STATES AIR FORCE

WASHINGTON DC

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MEMORANDUM FOR ALMAJCOM/SG

FROM: HQ USAF/SG
110 Luke Avenue, Room 400
Bolling AFB, DC 20332-7050

SUBJECT: Service-Specific Implementation Plan for Primary Care Manager by Name Initiative

Attached is the Air Force plan for the service-specific aspects of assigning each of our Military Treatment Facility (MTF) Prime enrollees to a specific Primary Care Manager (PCM), or "PCM by Name." This will be a tremendous stride towards optimizing health care delivery in our system and meeting the needs of our patients.

By no means is this a stand-alone initiative. It incorporates other key aspects of Air Force Medical Service optimization, including Population Health Improvement and the enrollment-based staffing model, to name a few. Most important, it is based on providing our patients what they want most: a medical system able to care for them personally.

I applaud those MTFs which have already implemented PCM by Name and encourage you to share your field experiences with other facilities. In drafting this plan, every effort was made to provide MTFs the maximum flexibility in shaping their individual programs and to allow those programs already in existence to continue. Because certain elements must be standardized across the system, some MTFs currently executing PCM by Name will need to modify their practices. I appreciate the understanding of those facilities which must change.

Publication of this plan is not the end of the process – it is the beginning. I anticipate there will be new issues raised and further guidance issued. I expect facilities to work closely with their Lead Agents to ensure implementation is done in concert with regional contract requirements and policies. My POC for this plan is Lt Col (Dr.) Ed LeBlanc, HQ USAF/SGMA, DSN 297-4699

LEONARD M. RANDOLPH, JR.
Major General, USAF, MC
Deputy Surgeon General

Attachment:
Air Force Implementation Plan for PCM by Name

Air Force Implementation Plan
for
Assigning Each Military Treatment Facility TRICARE Prime Enrollee to a Specific Primary Care Manager (PCM) by Name
("PCM by Name")

Introduction:

This plan presents the Air Force strategy for implementing the PCM by Name (PCMBN) concept as described in ASD(HA) Policy Memorandum 99-00033 – Individual Assignments to Primary Care Managers by Name, 3 Dec 99.

Although this memo directed the Surgeons General to develop service-specific plans, the nature of regional Managed Care Support (MCS) contracts require certain elements of implementing PCMBN be consistent across the Military Health Services (MHS). These aspects will be developed and fielded separately by the TRICARE Management Activity (TMA).

Assigning each TRICARE Prime enrollee to an individual PCM does not represent a stand-alone initiative. It is part of an overall process to re-engineer the MHS to become more effective at meeting the expectations of our patient population and line leaders. As such, this initiative will drive other changes that directly support the optimization of primary care within the direct care system. Therefore, many aspects of this plan have been developed to support other aspects of primary care optimization.

Policies on enrollment capacities, clinic schedules, PCM access, etc. are beyond the scope of this document but will be discussed briefly as they relate to the PCMBN policy.

Substantial revisions of the Defense Eligibility and Enrollment Reporting System (DEERS) are underway to specifically enhance TRICARE enrollment and portability. These will have a direct effect on the PCMBN initiative. It is essential that MTFs work closely with their Lead Agents and contractors while implementing PCMBN to ensure their plans are consistent with the changes in DEERS. Despite the relationship between changes in DEERS and the implementation of PCMBN, this plan has been written to be executable under the current DEERS environment.

At the time of this plan's writing, TMA is working to transition nearly all appointing and referral to the Managed Care (MCP) module of the Composite Health Care System (CHCS). This fact influenced many of the discussions, policies, and recommendations below.

Because implementing PCMBN is neither entirely a service-specific issue or the only part of optimizing primary care, this document contains more background discussions and suggested solutions than typical plans. In this document, policies will be considered directive in nature; guidance may be followed at the discretion of the military treatment facility (MTF).

Many discussions, policies, and points of guidance are inter-related. This document should be seen as a whole plan and must be read in its entirety to understand the overall execution strategy. Potential questions raised by one policy are likely addressed later in the document.

This plan becomes effective 1 Feb 00 with full execution expected by 1 Oct 00.

Objectives:

The overall objective of this Air Force plan is to enhance patient care and satisfaction by establishing a two-way health care relationship between each MTF TRICARE Prime enrollee and a specific MTF provider responsible for their primary care needs. Simply assigning the name of a provider to each enrollee will not suffice. Clinic processes must be restructured to optimize the relationship between the patient and the provider.

In support of this objective, key metrics which allow accurate assessment and comparisons of PCM performance will be developed. This will be one of the factors in determining enrollment, appointing, and referral methods.

I. Issue: Definition of "PCM"

Discussion:

ASD(HA) Policy Memo 99-00033 states, in part, that "Individual PCMs are typically family practitioners, internists, pediatricians, and general practitioners. With appropriate physician consultation/supervision, physician assistants, nurse practitioners, nurse midwives and independent duty corpsmen *may* (emphasis added) also serve as PCMs." It further states "Specialists….may also serve as PCMs when appropriate." Aspects of these statements are not consistent with current Air Force policies and practices.

Many patients with complex medical conditions require primary care beyond the scope of the average primary care practitioner. In these cases, a specialist may be better suited to serve as the PCM if properly qualified to manage a patient's primary care needs.

The memo further states "Housestaff should not be formally assigned as the *sole* PCM because they must provide care *under the supervision of a privileged staff member* (emphasis added)." Residency Review Committee requirements and the nature of appointing systems determine some of the operational factors in how housestaff will be treated as PCMs within the HA guidelines.

The term "PCM" implies different things to the MCS contractors than to the MTFs. The policy and guidance below is intended to define which providers an MTF can identify to their MCS contractor as a PCM. Further policies and guidance on enrollment limitations and procedures for PCMs are listed below. A PCM as defined in this plan does not require any specific number of enrollees as dictated by other policies.

Policy:

A. A PCM is a properly credentialed and privileged MTF provider who is qualified to provide for the primary care needs of a patient as determined by the medical history and condition of the patient.

B. Independent duty medical technicians (IDMTs) will not serve as PCMs but may continue their current scope of practice under appropriate physician supervision in accordance with current applicable AFIs. Patients primarily cared for by IDMTs will be enrolled to a PCM as described under (A) above. This will typically be the IDMT's supervising physician or a

provider at the patient's base of assignment. Patients living and working over 50 miles from an MTF and cared for by IDMTs are eligible for the TRICARE Prime Remote (TPR) program and will have a civilian PCM in accordance with that program.

C. Housestaff will serve as PCMs for the purposes of this plan but remain under the direct supervision of their residency attending staff as per applicable training program guidelines.

D. MTFs will identify their providers who may be considered PCMs and forward this information to their Lead Agent and/or MCS contractor as required by regional policies. This is to ensure MCS contractors recognize a provider as a PCM in their system; it is not intended to define PCM enrollment capacity, describe limits on patient types to be enrolled to the individual PCM, list assignment of enrollees to PCMs, etc.

E. MTFs will not change the PCM status of a provider within CHCS or MCS contractor systems without the full coordination and support of their Lead Agent.

Guidance:

A. MTFs should re-evaluate their providers and determine who is qualified to serve as a PCM, and for what population of patients. Examples:

- A pediatrician is qualified to provide care for pediatric patients and may therefore serve as their PCM but may not be qualified to serve as the PCM for adults.

- A cardiologist who has suitable training and experience to manage common primary care conditions may serve as the PCM for a patient with complex cardiac disease. One who does not have the proper background may see cardiac patients as a specialist but may not serve as the patient's PCM.

- A GYN Nurse Practitioner not experienced in managing non-GYN primary care conditions would not be considered a PCM.

B. Specialists who will serve as PCMs, including pediatricians and internists, must determine how their schedules will be managed such that appointments are available to their enrollees (as their PCM) and to other beneficiaries (as a consultant).

II. Issue: Assignment to a PCM

Discussion:

From the MCS contractor's perspective, the "PCM" has several specific attributes. For example, it is the entity (whether a group or individual) whose appointments will appear first when a patient enrolled in TRICARE Prime calls for one. It is also the entity authorized to refer a patient for care beyond the scope of the PCM. Because of this, assignment of a PCMBN must be done in light of these facts.

Given the variety of PCM capabilities based on the definition above, there is clearly a need to ensure patients are assigned a proper PCM. The benefits of assigning a PCMBN must be balanced against the need for providers to practice within the scope of their training and experience. Considering all potential PCMs as equals and randomly assigning patients to them will result in providers being responsible for patients with medical conditions beyond their level of expertise. There is a need to distinguish between PCMs to whom the MCS contractor may assign new enrollees and those PCMs whose enrollees must be individually approved by the PCM. An example of the latter would be a cardiologist qualified to manage the primary care needs of patients with complex cardiac problems.

Patients who choose their own PCM have been shown to have greater satisfaction with their care than those who do not. Patient satisfaction is a significant determinant of perceived quality of health care. In many cases, however, newly-arriving patients will have no preference.

Patients who have chosen a physician PCM but whose health care needs suggest they could be appropriately managed with a physician extender as their PCM warrant special consideration, especially when groups are attempting to balance enrollment numbers. Beneficiaries should clearly understand the relationship between the physician and the extender when working with them to accept assignment to a physician extender.

At present, new recruits in Trainee status are generally not enrolled in TRICARE Prime at their training locations. As such, they are not ordinarily MTF Prime enrollees and are therefore technically beyond the scope of this plan. TMA is currently considering enrolling trainees at their training location. If this occurs, they may be managed under this plan as any other Prime enrollee.

Several teaching facilities have adopted strategies to support their training programs by enabling select Medicare-eligible beneficiaries to receive care at the facility with more continuity than for the average space-available patient. The implementation of PCMBN and reliance on the MCP module present particular problems ensuring these patients can continue receiving the continuity of care they need. This issue is being worked by TMA as part of requiring consistent use of the MCP module and is beyond the scope of this document.

A similar situation exists for foreign military members entitled to care at US MTFs while stationed in the US. This issue will also be addressed by TMA as part of the same plan.

Active Duty members deployed for extensive periods to remote locations or assigned to similar areas supported by an IDMT are essentially removed from the TRICARE environment. If they do not qualify for the TPR program, they are typically best managed by a PCM at their base of assignment.

Knowing the medical needs of our patients is key to ensuring they are assigned the right PCM. Maximizing completion of Health Evaluation and Reporting (HEAR) forms to use the data effectively will contribute significantly to optimizing PCM assignment.

Many facilities must transition from group PCMs to PCMBN. This will require processes above the level of service-specific development and are beyond the scope of this particular plan. Such guidance will be provided elsewhere but MTFs must ensure their plans fully comply with regional requirements and do not inadvertently cause problems with appointing or claims processing for patients.

The policies and guidance provided below describe the end state MTFs are expected to comply with by 1 Oct 00. It is recognized that many tasks are dependent upon changes at the regional or Military Health System (MHS) level and may be beyond the control of the MTF.

Policy:

A. For each PCM identified above, MTFs will determine the types of patients for which they may serve as PCM and whether or not the MCS contractor may enroll directly to the PCM.

B. MTFs will identify to the contractor those PCMs who may accept direct enrollment from the contractor. They will provide the contractor with the criteria and limits for enrollment to that PCM, such as patient age, as well as overall enrollment capacity for each individual PCM. As soon as practical, MTFs will inform contractors of start dates to begin assigning enrollees to a PCM as well as the last date they may accept new enrollees (as determined by PCM departure). MTFs will coordinate with their contractor to ensure the contractor does not enroll beyond a PCM's capacity without MTF approval. All of these actions will be performed in accordance with regional requirements and policies.

C. MCS contractors will not be allowed to enroll directly to housestaff. MTFs will ensure appropriate arrangements are made with MCS contractors to prevent this.

D. MTFs will work with their Lead Agent and MCS contractor to establish efficient methods of transferring enrollee assignment from one PCM to another.

E. Panel capacity, provider qualification, and regional policies permitting, patients may enroll to an MTF PCM of their choosing and may change at their discretion. MTFs must advertise the patient's ability to choose their PCM. Changes in enrollment must be done in accordance with regional requirements.

F. Enrollees will be informed in writing of any changes in PCM assignment, including initial enrollment to a facility. At a minimum, this information will include individual PCM of assignment, group name (if applicable), effective date, partnered physician (for physician extenders), and telephone contact numbers.

G. All MTF TRICARE Prime enrollees will be enrolled to one specific individual as their PCM.

Guidance:

A. MTFs may consider assigning enrollees to the appropriate PCM through several possible methods, as determined by regional guidelines and contracts (which may be modified by MOU). The following suggestions are a few examples:

(1) Require MCS Contractors to assign all patients to primary care physician PCMs who then triage enrollees, using HEAR forms, records reviews, or other methods, and re-assign appropriate patients to physician extender PCMs on their group or, for patients with complex illnesses, to a specialist PCM. Although this option involves re-assignment of the PCMBN in many cases, it allows facilities the greatest control over panel size and complexity for each PCM.

(2) Allow MCS Contractors to assign patients to all identified primary care PCMs without triage, including physician extenders, then allow PCMs to reassign enrollees based on their medical needs. This option means many patients with complex illnesses may first be assigned to a PCM not appropriate for their level of needed care and will need to be reassigned after their first visit.

(3) Require all patients be enrolled to a physician who remains their PCMBN. Physician extenders are provided appointment templates which allow them to see enrollees for select types of medical visits only, such as urgent care, Pap smears, well-baby exams, and Periodic Health Assessments. Under this option, extenders would not function as true PCMs but would support the physician.

B. If residency programs permit MCS contractors to enroll patients to their panels, they should require all new enrollees be initially assigned to an attending physician. They may then be triaged to the appropriate resident for true "PCM by Name" enrollment. This method allows the program to appropriately manage housestaff panels. Proper backup by attending physicians on their group ensures they are not the "sole PCM."

C. Patients enrolled to a specialist PCM should be included in MTF Case Management programs and should have a primary care provider identified as their "primary care PCM." This would be an informal identification outside of the contractor's system but would allow a primary care provider to actively participate in a patient's care and be a consultant to the specialist on primary care issues. Should the patient's medical condition permit, they could be reassigned to the primary care provider as their PCM. Enrollment in Case Management may not be needed for pregnant women whose PCM is an obstetrician during pregnancy but may serve as a means of ensuring the patient is properly reassigned to a primary care provider following the pregnancy.

D. Enrollment applications which only provide a list of PCMs force patients to choose one. New arrivals will likely have no preference and may be assigned to a provider with fewer enrollees. MTFs are encouraged to include “no preference” as an option for PCM selection, to facilitate balancing panels.

E. Informing patients of their PCM assignment presents the opportunity for the PCM to “introduce” themselves and their group. Many civilian practices use letterhead which includes the names and specialties of partners. Office hours, after-hours contact procedures, Health Care Integrator contact information, and other useful facts, are also appropriate to include.

F. Facilities participating in TRICARE Senior Prime must ensure their PCM assignment actions comply with the requirements of that program.

III. Issue: Groups of PCMs

Discussion:

Clearly no PCM can be available at all times for their patients. Cross-coverage among PCMs with similar scopes of practice is necessary. To facilitate the relationship between PCMs and their patients, the number of PCMs a patient may see in the absence of the primary PCM must be limited. Furthermore, the other PCMs on the group must be able to provide comparable levels of care to enrollees to all PCMs of the group to the maximum extent possible.

PCM groups will be expected to be smaller than some MTFs currently employ. Groups will be the level at which the requirements of PCMs as described by HA Policy 96-060, Policy for After-Hours Care for TRICARE Prime Enrollees, will be met. This will likely result in more frequent call for PCMs in many locations but this will be offset by coverage of smaller numbers of enrollees and decreased after-hours calls to the PCM through better demand management. Less frequent calls to the PCM after hours may realistically allow call to be taken in blocks of several days per PCM, especially if coupled with later clinic start times the following day for the PCM. For example, a PCM may be on call for an entire week and work 1100-2000 on those days.

Recent Air Force Medical Service (AFMS) directives regarding appropriate staffing to support PCMs has evolved into a concept of aligning PCMs into blocks of four, with their appropriate support staff organized into a "PCM block." This approach, modeled after the flying community's "Primary Aircraft Authorized" (PAA) concept, provides the opportunity to develop a rational means of forming PCM groups for this plan which align with support staffing standards, access management strategies, and other primary care optimization efforts. Two such blocks, providing eight PCMs, would provide a realistic group size as well as appropriate support staffing and reasonable familiarity between PCMs and group patients.

The term "group" in this plan is intended to be consistent with the use of the term within the MCP module of CHCS. Given the nature of the MCP module, no PCM may be a PCM of more than one group. This will affect both PCM assignment to a group and patient assignment to a PCM, especially specialists. Those specialists who wish to be PCMs for certain patients must be a PCM of a group capable of providing appropriate backup in their absence within the capabilities of the MCP module.

Although MCP does not allow a provider to be a PCM on more than one group, providers may be members of other groups, as well. This allows a solo pediatrician, for example, to have their own panel of enrollees on one group but be considered a group member for other groups within the MTF. It also allows non-PCMs, such as Gyn Nurse Practitioners, to be available as providers (but not PCMs) on several groups. This discussion is provided to offer MTFs potential tools for forming their groups. Further discussion of MCP attributes is beyond the scope of this plan.

Policy:

A. PCMs will be organized into groups of other PCMs with comparable clinical capabilities to the maximum extent permitted by MTF staffing. Groups will be comprised of eight PCMs whenever possible but will be sized, within the limits of MTF staffing, to meet the expectations of providing appropriate continuity of care to patients.

B. All PCMs will be assigned to a group.

C. Residency programs will ensure that groups are formed within the oversight requirements of their programs by having the appropriate balance of housestaff and attending physicians.

D. MTFs will ensure PCM templates and schedules are managed such that appointment access standards for Prime enrollees to PCMs on each group are met by the group. This includes meeting these standards during deployment of PCMs.

Guidance:

A. MTFs should work to align group composition with the "PCM block" concept to the maximum extent feasible. This will provide appropriate support staff to facilitate access management, case management, triage, etc. It is unlikely a group will need to have more than ten or eleven PCMs. If there are more than this, two groups would be more appropriate.

B. In support of the "PCM block" concept, MTFs should attempt to create groups using four providers assigned to the facility as full-time PCMs and augment groups with part-time PCMs, such as the SGH, as needed. This will more properly align the support staffing with the group and allow for the creation of groups not comprised of eight PCMs.

C. MTFs are expected to manage appointment templates, assignment of PCMs to groups, and provider absences to ensure the group meets access standards for all enrollees to that group's members. Visits for routine care to providers outside the group will be a future AFMS metric.

IV. Issue: Appointing and Referral Processes

Discussion:

Given the objectives of optimizing the relationship between the patient and their PCM and being able to accurately measure PCM performance, the MCP module serves as the best tool within CHCS to manage patient appointing and referrals. Not only does this module maximize use of the PCM for appointing, it also allows appropriate backup by a group of PCMs. Furthermore, it provides a source of accurate appointing and referral data which is consistent across the MHS.

Many facilities are currently using the MCP module for scheduling, some as required by regional contracts. Other facilities have relied upon the BOK feature within CHCS. This option does not allow for the proper management of PCM appointments and does not easily permit consistent data comparisons between PCMs and facilities. Several facilities have developed "work-around" solutions within this module which are not consistent with the objectives of this plan.

As mentioned in the Introduction to this plan, several potential problems exist with the use of the MCP module for particular situations. None of these appear insurmountable.

There are also situations where non-MCP booking of appointments may need to continue. These will be identified at the time of implementation of full MCP usage and will be limited to those situations where MCP booking is not feasible. Specifically, however, booking of appointments for flying personnel or periodic health exams will not be excluded from MCP usage.

Regardless of whether or not MCP becomes the required means of appointment booking and referral, it will eventually be the source of PCM performance data within the AFMS. Those facilities not using this module will not be accurately reported.

Policy:

A. MTFs not currently using the MCP module for appointing and referrals will immediately develop strategies to transition to this. This should include working with Lead Agent resources to identify and meet training needs.

Guidance:

A. Use of the MCP module will dramatically alter how and where some patients receive care. It will not permit patients enrolled at one facility to easily receive care at another, for example. MTFs should educate their enrollees that enrollment to a PCM is a commitment by them to see that PCM or a group member for all primary care. They should be advised to ensure they are enrolled at the facility where they wish to receive care.